Statement For the Record of the Hearing of the
House Energy and Commerce Committee
Subcommittee on Health
On
"Medicare Physician Payment:
How to Build a More Efficient Payment System."

Testimony of the American College of Physicians
In Collaboration with
the American Academy of Family Physicians
And
American Osteopathic Association
On
The Impact of Medicare Payment Cuts on Access to Primary Care

November 17, 2005

Introduction

My name is Vineet Arora, MD, chair of the Council of Associates of the American College of Physicians and a member of the College's Board of Regents. I am an Instructor of Medicine in the Section of General Internal Medicine at the University of Chicago where I did my internal medicine residency. As an attending physician on staff, I, along with the residents and medical students I supervise, currently see a large number of Medicare patients. We deliver primary care to the residents on the South Side of Chicago; 85% of these patients are African American and the majority is over age 65 and covered by Medicare. I also serve as the Associate Program Director for the Internal Medicine Residency Program and the Assistant Dean for the Pritzker School of Medicine. In this role, I advise students and residents regarding their future careers.

ACP is the nation's largest medical specialty society, representing 119,000 physicians who specialize in internal medicine and medical students. ACP's Council of Associates, which I chair, represents physicians who are being trained in an internal medicine residency program or who have gone on for additional training in a subspecialty medicine fellowship program. *We are the new generation of physicians that your elderly and disabled constituents will be counting on for their primary care.*

Unfortunately, there won't be enough of us. A combination of high student debt and an unfavorable economic environment is causing many of us to choose careers other than general internal medicine or family practice—the two specialties that aged and disabled patients most depend on for their primary care. According to CMS, in 2004 almost half of all Medicare expenditures on office visits were for services provided by primary care physicians. Medicare payment cuts that will result from the flawed Sustainable Growth Rate (SGR) formula will accelerate this looming crisis in access to primary care.

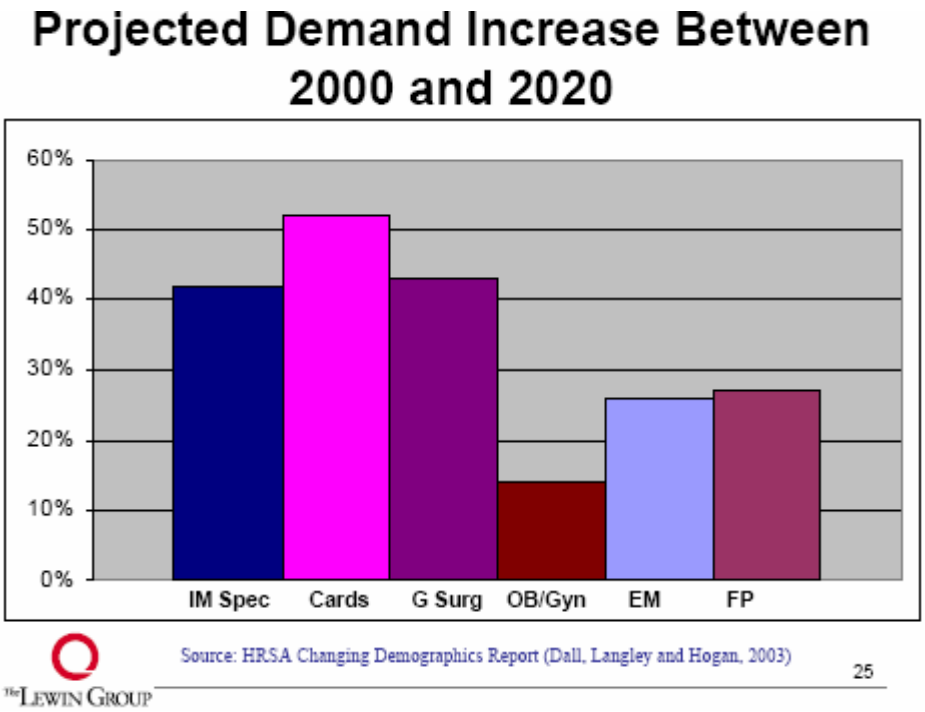
Last week, representatives from the American College of Physicians, American Academy of Family Physicians, and the American Osteopathic Association visited members of both the House and Senate to share our concerns about the impact of Medicare payment cuts on access and quality of care for Medicare patients. Together, our three organizations represent approximately a quarter-million physicians and medical student members. Today's testimony will summarize and elaborate on the points we made in our joint visits. *I am pleased to report that the American Academy of Family Physicians and the American Osteopathic Association participated in the preparation of today's testimony*

and asked for the record of the hearing to reflect that they concur with the views expressed. (The American Academy of Family Physicians and the American Osteopathic Association will also be submitting their own statements for the record of this hearing).

The Looming Crisis in Access to Primary Care

There is growing evidence that shortages are developing for U.S. physicians, particularly in general internal medicine and family practice. Previous expectations of an excess supply of physicians have not materialized. Current projections indicate that the future supply of primary care physicians will be inadequate to meet the health care needs of the aging U.S. population, especially as "Baby Boomers" are beginning to reach retirement age in 2011, when they will be at increased risk for needing health-care services.

The chart below illustrates the dramatic increase in demand for certain physicians:



The aggregate demand numbers do not tell the whole story, however. As illustrated in the following chart, as adult patients age, their need for primary care physicians increases dramatically, requiring proportionately more physicians per 100,000 population to meet the increased demand:

What Aggregate Numbers Don't Show

Est. Demand for Patient Care Physicians per 100,000 Population, by Patient Age: 2000

Age Group	Specialty				
	Primary Care	Medical Specialties	Surgery	Other Care	Total
0–17	97	10	16	30	**153**
18–24	44	15	56	49	**165**
25–44	60	24	54	64	**202**
45–64	91	42	61	84	**278**
65–74	179	100	129	150	**558**
75+	276	134	166	227	**804**
Total	**96**	**34**	**57**	**73**	**261**

- Most specialties disproportionately serve patients of a certain age, gender, etc.

Source: HRSA Changing Demographics Report (Dall, Langley and Hogan, 2003)

The Lewin Group

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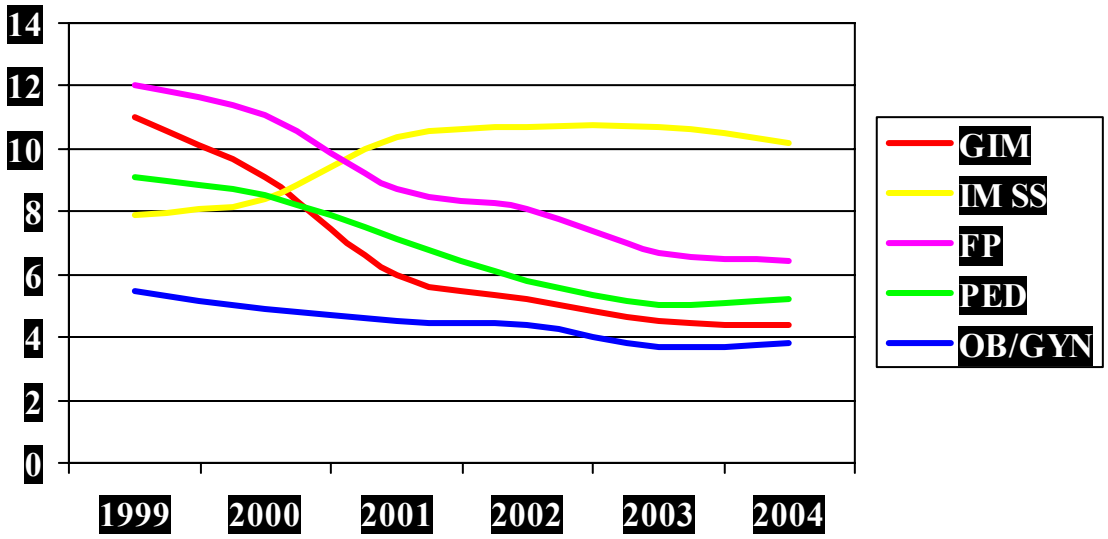
The Association of American Medical Colleges exit survey of graduating seniors found that the number of students choosing GIM as a career has dropped precipitously in the past 4 years (12.2% in 1999, 10.2% in 2000, 6.7% in 2001, and 5.9% in 2002).

Interest in Entering Primary Care has been Declining
Among Graduating Medical School Seniors (Percentages)



Source: AAMC Medical School Graduation Questionnaires: All School Reports 1999-2004, Table 25b Choice of Specialty/Subspecialty. http://www.aamc.org/data/gq/allschoolsreports/2004.pdf

Another recently-published study of the career plans of internal medicine residents documents the steep decline in the willingness of physicians to go into primary care. In 1998, 54% of third year internal medicine residents planned to practice general internal medicine compared with 27% in 2003. Strikingly, in 2003, only 19% of first year internal medicine residents planned to pursue careers in general medicine.

The trend away from primary care has been well documented by the annual residency training match sponsored by the National Resident Matching Program (NRMP). The number of U.S. medical school graduates who choose to enter generalist residency training has decreased from 50 percent in 1998 to less than 40% in 2004. The decline has been greatest in family medicine training programs, which has declined 41%. Internal medicine and pediatrics declined by 9% and 8% respectively. In the 2004 match, the

percentage of residency training positions filled by U.S. medical school graduates was only 41% in family practice, 55% in internal medicine residencies and 71% in pediatrics.

Reversing this decline will require immediate action by policymakers. The long pipeline of medical education and training and the retirement and career changes of older physicians necessitates that the nation have a constant influx of new students embarking on medical careers. As the population ages, and larger numbers of patients encounter chronic and more complex illnesses, the need for general internists and family physicians will increase. The need for primary care physicians, who can provide first contact and comprehensive continuing care for adults, will continue to increase as the population ages and its health care needs increase, and as the demand for acute, chronic and long-term care increases.

Economics of Primary Care and Career Choice

The reasons why medical students and young physicians are turning away from primary care are complex and multifaceted. But based on my own experience, and from my conversations with my peers, I can say with confidence that that the dismal economic practice environment associated with primary care today is the major barrier. The pending Medicare payment cuts will only make a bad situation even worse.

Medical students and young physicians learn early on in our training about the joys of having a continuous, ongoing and personal relationship with a patient, which is the hallmark of general internal medicine and family medicine. Unfortunately, we also learn that primary care is under-reimbursed compared to other specialties, and that many primary care

physicians are struggling to keep their practices open at a time of escalating practice costs, excessive paperwork requirements that take time away from patients, and reimbursement from Medicare and other payers that does not keep pace with their rising costs. It is so bad that many of the excellent primary care physicians that we meet in our training programs go as far as to counsel us *not* to go into primary care. Why? Because they tell us that there is no economic future in primary care.

Part of this is due to fact that we are entering practice with very high student debt. Excessive levels of debt mean that it is less likely that we will go into specialties, like general internal medicine and family practice, which are reimbursed so poorly that it will take decades to pay off our debt. Today, a physician entering practice has on average accumulated more than $100,000 in student debt. The median indebtedness of medical school students graduating this year is expected to be $120,000 for students in public medical schools and $160,000 for students attending private medical schools. About 5% of all medical students will graduate with more than debt of $200,000 or more. Many of us are entering practice at the same time we are getting married, buying homes, and starting families. Is it any surprise that more and more of us have concluded that we simply cannot afford to support our families and also practice primary care?

Medicare Payment Cuts Will Accelerate the Access Crisis

Right now, physician payments under Medicare will be cut by 4.4 percent on January 1, 2006. Additional cuts will decrease physician reimbursement by more than 26 percent from 2006 to 2011. According to the Medicare Economic Index from CMS, physician

costs will rise by 15 percent during this same time period. The problem is that the cuts will accelerate the precipitous decline in physicians going into internal medicine and family practice, by making an already poor adverse economic environment even worse. The cuts will also limit the ability of physicians who are already in practice to continue to provide care to Medicare patients.

Because internists and family physicians see so many elderly patients, their practices will be particularly hurt by the cuts. And those in small practices will have the hardest time making ends meet. (According to a 2004 article in Health Affairs, more than half of all practicing physicians are in practices of three or fewer physicians, three-quarters are in practices of eight or fewer.) Small physician practices are small businesses. Like any small business, they cannot continue to provide the same level of service if revenue falls behind costs.

More than a third of today's physicians are age 55 and over. That's 304,641 of the country's 871,535 doctors who could be "pushed over the edge" by these Medicare cuts. They may decide to retire rather than deal with the Medicare cuts, at the same time that fewer young physicians are going into primary care, and those in practice who don't retire may be forced to limit the number of new Medicare patients they will accept. It will become harder for Medicare patients to find a doctor and they will wait longer for appointments.

Medicare will also pay more. According to an article published in the Annals of Internal

Medicine in July "Studies . . . have shown that hospitalization rates and expenditures for those conditions are higher in areas with fewer primary care physicians and limited access to primary care."

Medicare Cuts Will Also Set Back Quality Improvement

The SGR cuts will have other adverse consequences for the quality of patient care.

- *The cuts will set back the national goal of improving health care through Health Information Technology*

These cuts will fall hardest on the doctors who can least afford the investment needed to adopt health information technology (HIT): primary care physicians in small practices who see a large number of Medicare patients. In a landmark study published last month in *Health Affairs,* the authors reported that initial electronic health records (EHR) costs averaged $44,000 per full-time equivalent provider, and ongoing costs averaged $8,500 per provider per year for maintenance of the system. They concluded that **"**Policies should be designed to provide incentives and support services to help practices improve the quality of care by using EHRs."

A 2004 report by the Center for Studying Health System Change found a large majority of Americans receive their care from small or solo physician practices, but those practices are the least likely to have acquired health information technology to support key quality improvement activities. The report concluded that because barriers to HIT adoption appear to be greatest for smaller traditional physician practices, policy makers may need

to design policies specifically aimed at these physicians, noting that while the use of HIT in physicians' offices potentially can improve quality and reduce costs, implementation is costly because of up-front investments in capital, training and integrating HIT systems with existing administrative and clinical processes.

- *The cuts will set back the national goal of measuring and improving health care quality*

The Medicare fee cuts will fall hardest on the physicians that Medicare is most counting on to participate in quality measurement. Just two weeks ago, CMS proposed a new voluntary physician reporting program; out of the 36 measures proposed, 22 will apply principally to internal medicine specialists and other primary care physicians.

Physicians who participate in the program will need to train and dedicate office staff to tracking quality data and learning new reporting forms, technologies and billing codes that will have to be incorporated into existing office systems. They will then need to review regular reports on their quality and institute action plans to make improvements. Many small practices will simply be unable to take on this commitment if Medicare fee cuts deprive them of the resources needed. According to a study published less than three weeks ago in The Journal of the American Medical Association, one of the possible reasons for low response in a quality improvement program the authors studied is that "the financial rewards for quality were too low." Internal medicine doctors and family physicians are committed to the goal of measuring and improving health care quality, but Congress needs to do its part.

Conclusion

In conclusion, I urge the Subcommittee to recommend that Congress take action now to help avert the looming crisis in access to primary care. Medicare patients depend on internists and family physicians for their care, but there are not enough of us going into primary care. Medicare payment cuts will fall hardest on the primary care specialties that can least afford them. The cuts will accelerate the precipitous decline in medical students and young physicians going into primary care. The cuts will force many of those who are now in practice to retire early or limit how many Medicare patients they can see. The cuts will make it impossible for primary care physicians to make the investments required to obtain electronic health records and participate in quality measurement and reporting.

What can be done to avert this crisis?

First, Congress must stabilize Medicare payments by halting the 4.4 percent cut on January 1, 2006 and replacing the SGR cuts with positive updates for at least the next two years.

Second, Congress must enact a long-term alternative to the SGR. This alternative should base payments on increases in physician practice costs with the opportunity for physicians to qualify for additional payments for meeting quality improvement goals. It should allow physicians to benefit from achieving savings in other parts of Medicare, such as by reducing Part A expenses associated with unnecessary hospitalizations.

Third, Congress must recognize that successful implementation of a Medicare value-based purchasing program or pay-for-performance will require that the SGR be replaced with an alternative that provides stable, adequate and predictable payments to physicians.

Fourth, Congress should work with ACP, AAFP and AOA on developing a coordinated and comprehensive strategy for reversing the decline in physicians going into primary care. Such a strategy should address such factors as inequitable reimbursement, high levels of student debt, and excessive paperwork requirements imposed on primary care practices. It should also provide adequate financing for new and better ways of delivering primary care to patients, such as a "medical home" model where patients would have ongoing access to patient-centered, coordinated care through a personal physician working with a team of health care professionals. Under such a model, physicians would be paid a care management fee for providing managing and coordinating the care that they provide to their patients rather than being paid under the current episodic, volume-based fee for service system.

I am pleased to answer any questions from the Committee.

Summary of Statement by Vineet Arora, MD, chair of the Council of Associates of the American College of Physicians

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